Form for Requesting Social Security Information

TO: Social Security Administration

Name	**Date/Birth**	**Social Security No.**

I authorize the Social Security Administration to release information or records about me to:

Health Advocates Inc.
1410 N. Westshore Blvd. Suite 500
Tampa, FL 33607

HAI West - A Subsidiary of Health Advocates Inc.
15615 Alton Parkway, Suite 450
Laguna Hills, CA 92618

I want this information released because:
To establish my Social Security Disability status, date of entitlement to Medicare and the basis for Medicare entitlement (disability or age) for the purposes of my Workers' Compensation claim.
(There may be a charge for releasing information)

Please release the following information:

X Other: Social Security entitlement status, date of SS entitlement or date of application if still pending, basis for entitlement (disability, age, ESRD), Medicare status, date of entitlement for Medicare A and B, Supplemental Security Income entitlement, Medicaid entitlement. If not a current Social Security recipient, include number of eligible quarters.

____**Other:** Initial PIA, 80% ACE and Family Max (please check box if needed)

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature:_____
(Show signatures, names and address of two people if signed by mark)

Date: _____ **Relationship:**_____

DO NOT FILL OUT BELOW THIS LINE

Is claimant currently a **Medicare** and/or **Medicaid (SSI)** recipient? Yes____No____

Is claimant receiving: **Medicare Part A** _____ Date of Entitlement _____

Medicare Part B _____ Date of Entitlement _____

SSI/Medicaid _____ Date of Entitlement _____

------If claimant is receiving Medicare/Medicaid benefits, do not continue to the next question.------

Is claimant receiving **SS Retirement Benefits**? Yes____ No____

Effective Date _____

Is claimant receiving **SSD** benefits but is not yet a Medicare beneficiary? Yes____ No____

Date of entitlement to **SSD**: _____

Has a claim or request for hearing for **SSD/SSI** benefits been filed? Yes____ No____

Date of Application: _____

Is claimant insured for **SSD**? Yes____ No____

Initial PIA_____ ACE_____ Fam Max_____

SSA Representative Signature_____ **Date**_____